# Enrollment and Disenrollment in Subsidized Health Insurance:

## Lessons Learned in Massachusetts

## INTRODUCTION

### Statement of the Problem for Individuals with Behavioral Health Needs

More than 97 percent of the Massachusetts population has health insurance as a result of the new programs with expanded eligibility included in the state's 2006 healthcare reform law and from a series of concerted outreach and enrollment efforts. [i] Despite this high-level of coverage among the general population, many behavioral health experts familiar with Massachusetts identified a disproportionately lower rate of coverage among individuals presenting for community behavioral health services in Massachusetts[ii]. This led the Substance Abuse and Mental Health Services Administration (SAMHSA) to seek to confirm these allegations, explore possible causes, and identify strategies for maximizing coverage among individuals with behavioral health conditions in Massachusetts and across the country. The report is based on information drawn from structured discussions and focus groups performed in July of 2011 under the SAMHSA Financing Center of Excellence contract.

Across the discussions and SAMHSA organized focus groups contributing to this report, CEOs of community mental health centers and addiction treatment agencies estimate that more than 20 percent of patients are uninsured when needing emergency acute services. Many of these patients have experienced a phenomenon called 'churn', the phenomenon of an individual previously determined eligible for health insurance coverage losing such coverage and then regaining the same coverage within a short period of time (i.e. 6 months or less). Churning is usually due to an individual not complying with administrative requirements rather than because the individual no longer meeting eligibility requirements. [iii]. The observations that those with behavioral health disorders often churn on and off coverage are further reinforced by behavioral health consumers who indicated that about 50 percent of them had been uninsured at least once during the previous year.

In addition, the discussions provided further evidence that a substantial proportion of the uninsured presenting for substance abuse treatment services are young men[iv]. Data from the Massachusetts's Department of Public Health found that the uninsured individuals presenting for detoxification services were primarily 18- to 25-year-old males.[v] These men are at high risk for developing more chronic substance abuse use disorders, and a lack of insurance coverage embodies a significant barrier to accessing evidence-based treatment that can help lead to recovery. These findings identify an enrollment challenge distinct from churning because young individuals are often uninsured because they are less convinced of the need for health insurance coverage and therefore don't take steps to enroll. They embody a unique outreach and enrollment challenge in an age group that manifests high drug abuse. Yet enrollment issues with this young uninsured group are critically important, as research indicates that young, childless individuals will likely compose nearly half of the uninsured population remaining after the implementation of the Affordable Care Act in 2014[vi].

This report provides a brief literature review of research on eligibility determination, enrollment, and recertification systems for the national publically funded health insurance programs, summarizes the Massachusetts eligibility determination, enrollment, and recertification system, outlines the key findings from SAMHSA's research, and outlines specific strategies that Massachusetts and other states should pursue in order to maximize coverage for individuals with behavioral health conditions.

## METHODOLOGY

This is a qualitative evaluative study that includes observations and findings based on:

- Structured discussions with key administrative and policy personnel involved in insurance, enrollment, advocacy, and behavioral health service delivery functions;
- Focus groups with patient volunteers currently receiving services for serious mental illness and/or acute substance use disorders.

There are some additional aspects to the focus group methodology worth noting. The quantitative data on the uninsured in Massachusetts and nationwide paints a picture of a heterogeneous group of varying ages, incomes, ethnic and cultural background, and medical needs.[vii] Yet the volunteer patient

participants in our focus groups were primarily 30-55 years old, low-income, English speaking, white or African-American individuals with persistent mental health and/or substance use conditions. Unfortunately, we were unable to engage the Massachusetts low incomes populations who are either unaware of their eligibility for insurance coverage programs or those not convinced of the need for coverage.

## LITERATURE ON INSURANCE ELIGIBILITY DETERMINATION, ENROLLMENT, AND RECERTIFICATION

There is a significant body of literature on the role of health insurance coverage in helping individuals maintain their health status, including multiple consensus reports from the Institute of Medicine[viii]. In addition, the first randomized study on the impact of health insurance coverage was recently conducted in Oregon showing "the treatment group had substantively and statistically significantly higher health care utilization (including primary and preventive care as well as hospitalizations), lower out-of-pocket medical expenditures and medical debt (including fewer bills sent to collection), and better self-reported physical and mental health than the control group[ix]."

Management of eligibility-based public health insurance programs requires accurate eligibility determination processes to assure responsible stewardship of limited public resources. The Medicaid Program and Children's Health Insurance Program (CHIP) are joint partnership between the Federal Government and States. Yet within broad Federal guidance and regulations, each state has developed its own unique set of eligibility rules, processes, and infrastructure for Medicaid and CHIP eligibility determinations[x]. There is a significant body of research testifying to the important role state choices around their eligibility determination, enrollment, and recertification processes in either helping or impeding eligible individuals' access to continuous coverage[xi]. A major issue that has been raised in this literature review is the key issue of coverage continuity. For example, a national report found that 38 percent of the population under 65 experiences a break in health insurance coverage over a three-year period.[xii] As the expansions in coverage eligibility included in the 2010 Affordable Care Act (ACA) go into effect in 2014 and establishes programs similar to those in place in Massachusetts, researchers and policymakers are predicting that the issue of coverage continuity will not diminish without significant

and coordinated Federal and State efforts[xiii]. SAMHSA analyses using the National Survey on Drug Use and Health (NSDUH) has found that there are more than 11 million currently uninsured individuals with behavioral health needs who will likely become eligible for affordable coverage under the ACA[xiv]. The literature on the causes of breaks in coverage (i.e. income, housing volatility, etc), and the higher prevalence of behavioral health conditions among the uninsured points to a interrelationship between behavioral health symptoms and difficulties complying with administrative requirements in applying and maintaining continuous coverage. Unless concerted and coordinated Federal and State efforts are made these enrollment difficulties will likely continue when those currently uninsured have opportunities under ACA coverage expansions to gain coverage through Medicaid or State Exchanges.

## MASSACHUSETTS ELIGIBILITY, ENROLLMENT, AND RECERTIFICATION SYSTEM

### Operating Policies and Procedures

The report focuses on two publicly subsidized Massachusetts health care programs:

- The MassHealth Program, which includes both the State's Medicaid Program and the State's Children Health Insurance Program (SCHIP) within Massachusetts,
- The Commonwealth Care Program, the state's subsidized health insurance program offered through the state's health insurance exchange, the Health Connector.

Massachusetts also provides access to a program called the Health Safety Net which helps pay for health services for certain low-income uninsured and underinsured individuals. However, the Health Safety Net will only pay for medically necessary services that are on the list of MassHealth Standard covered services and only as long as the services are provided by Massachusetts community health centers or hospitals. Since the Health Safety Net does not contract with community mental health or substance abuse treatment centers, its eligibility determination and enrollment practices are largely not addressed in this report[xv].

MassHealth has the responsibility for performing program eligibility determinations for MassHealth, Commonwealth Care, and the Health Safety Net via a single application called the Medical Benefit Request (MBR) Form (or the Senior Medical Benefit Request (SMBR) Form for seniors or other

individuals needing long-term care services)[xvi]. The MBR Form is available in paper form or can be completed online with the assistance of a Virtual Gateway provider (for more information on the Virtual Gateway, see discussion below on the MA's Information Technology Infrastructure). The application must be completed and mailed to MassHealth along with any required verifications such as proof of income, citizenship, and identity. If more information is needed to process the application, MassHealth will send a letter to the applicant requesting the information within the required timelines (for applicants under age 65 are provided 60 days to return information and applicants age 65 years and older are provided with 30 days to return information). Each type of coverage within MassHealth (Standard, CommonHealth, Family Assistance, Basic, Essential, Prenatal, and Limited[xvii]) and Commonwealth Care (Plan Type 1, 2A, 2B, and 3[xviii]) have different eligibility criteria. The eligibility system determines an individual's eligibility through a cascade mechanism which begins with the most comprehensive coverage program offered and then moves on to less comprehensive programs until the individual is determined eligible (or not). In order to help streamline the initial application and annual continued eligibility review process, MassHealth conducts data matching with other State and Federal agencies to electronically verify whenever possible the information necessary to process cases. Once the appropriate program for the individual is identified, MassHealth sends the applicant an eligibility determination notice which provides guidance on what next steps are needed to enroll the person in the health plan and/or the steps needed to select a primary care doctor (this depends on the specific program the individual is eligible for). If the individual is determined ineligible, MassHealth sends a notice explaining the reason for the denial. All eligibility determination notices from MassHealth include information on appeals the individual can take if they dispute the denial of coverage determination.

After mailing the program eligibility determination notice to the applicant, the MassHealth (for Medicaid and SCHIP) and Commonwealth Care (State exchange) processes diverge in how the individual selects and enrolls in a health insurance plan, with each program having separate health plan enrollment processes and support infrastructure. For individuals determined to be eligible for a specific set of programs within MassHealth[1], they need to enroll within 14 days of the mailing of their program eligibility determination notice. If they do not make a selection by calling MassHealth customer service

[1] For MassHealth Basic and MassHealth Essential eligibles, MassHealth does not automatically enroll. The applicant must select a health plan and/or primary care physician to be enrolled.

or mailing in their selection to MassHealth within that period, MassHealth will automatically enroll them according to service area proximity to the individual's address. If a MassHealth member wants to make a change to the health insurance plan, they can do so be calling MassHealth customer service. For individuals determined to be eligible for Commonwealth Care, the programs fall into two general categories: those that require a consumer contribution in addition to the government payment for the health insurance premium (Type 2B and 3) and those that the government will pay the entire monthly premium (Type 1 and 2A[2]). Individuals who have been determined eligible for a premium-free plan within Commonwealth Care must select a plan online, by phone, or by mail. If this selection is received and processed by the 25th day of the month, coverage will begin on the first day of the following month. If the individual fails to select a plan, they will not be enrolled until they do so. Alternatively, individuals who have been determined to be eligible for a Commonwealth Care plan that requires a consumer contribution to the monthly premium follows the same enrollment process but will experience one additional step. Once the individual has selected a plan, a preliminary bill for the monthly contribution will be sent to them that must be paid and processed prior to the initiation of coverage.

The eligibility renewal[3] process for both MassHealth and Commonwealth Care is very similar to the preliminary enrollment process described above. MassHealth sends the annual eligibility review form to enrollees of all MassHealth or Commonwealth Care programs approximately 12 months after their original eligibility determination. The annual eligibility review form asks similar types of questions as the initial application and individuals are provided either 45 days for those under age 65 or 30 days for those 65 and older to respond. If any proof of the information is needed and MassHealth is unable to verify it through data matching, a request for information will be sent directly to the applicant. However, if the individual does not complete and submit the annual review within the required time period and there is insufficient data through matching information on hand to verify continued eligibility, the individual will be determined ineligible, disenrolled, and notified accordingly.

### The Information Technology Infrastructure for Enrollment

[2] There is at least one Type 2A plan available in each service area that has a $0 premium. However, there are also Type 2A plans that require a premium. If an individual selects one of the plans that require a premium but fails to pay that premium, they will be automatically transferred and enrolled into a $0 premium Type 2A plan.
[3] Also known as the recertification or reenrollment process

The information technology (IT) software infrastructure for MassHealth applications was developed over a decade ago. It is based on DOS operating system, and, while it has seen many modifications over the years, it is a legacy system that is not easily adapted to current data needs. The system is in early stages of redesign as part of a recent Center for Medicare and Medicaid Services (CMS) Innovation grant.

As mentioned previously, individuals must submit applications in paper format unless they can access online systems through a registered organization of the Virtual Gateway. The state registers community based organizations (advocacy organizations, MassHealth outreach and enrollment assistance grantees, all community health centers and hospitals) and grants them access to an online portal called the Virtual Gateway. Through the Virtual Gateway, these organizations can assist individuals in submitting an online application. However, applications submitted through the Virtual Gateway require supplemental paper forms to be sent in to complete the submission. A promising enrollee-targeted component of the Virtual Gateway is the web-based account service called "My Account Page." If the person who originally signed the application for benefits is already receiving benefits, they can use the "My Account Page" to view current coverage and update personal information[xix]. The "My Account Page" can be accessed directly from any computer with an internet connection.

### General Outreach Efforts and Enrollment Assistance

Under the Massachusetts' healthcare reform law, the new Health Connector Authority was given significant responsibility for outreach and enrollment efforts for those newly eligible. These efforts included the development of the Connector website (https://www.mahealthconnector.org/) and a public marketing campaign. The Connector website was designed to educate individuals about their insurance options as well as to provide a central location for selecting an insurance plan once an individual has received their eligibility determination.[xx] The marketing campaign aimed to educate individuals on the importance of health insurance, the new eligibility criteria, and the new individual insurance mandate. It also encouraged individuals to use the new website and other supports to find help with enrollment.[xxi] It should be noted that none of the outreach efforts focused on those with

behavioral health conditions specifically because the initial goal was simply to enroll as many uninsured individuals as possible regardless of health condition.

In addition to public marketing efforts of the Connector Authority, MassHealth developed a grant program to fund enrollment assistance efforts. The program provides mini-grants to organizations, including hospitals, community health centers, and patient advocacy organizations, and social service agencies. The grantees can focus on a specific population requiring more intensive engagement. These populations include: healthy individuals (particularly young adults) who do not identify with needing health insurance coverage, homebound (elderly/disabled), transient, or homeless individuals. MassHealth provides grantees and outreach workers (OWs) with quarterly training and technical assistance through the Massachusetts Health Care Training Forums. The forums serve as a learning network of organizations and provide participants with access to time-sensitive updates on eligibility, enrollment, and program policy from MassHealth staff. However, grantees and OWs indicated in the evaluation interviews that additional specific ongoing training and technical assistance from MassHealth should be provided to grantees, OWs and Virtual Gateway organizations on eligibility determination, enrollment, and benefit policy. To assist with this, MassHealth has recently linked outreach grantees to other training resources available through the MassHealth Member Education Unit and the Virtual Gateway training units. Although all grantees and OWs indicated that their outreach programs would be significantly impacted when grant funding is ended, some of which may not be able to continue to sustain providing services to clients without the funding support from MassHealth, the program may be terminated at the end of this calendar year unless additional funding is allocated.

The grantees and OWs working for the organization have identified a number of best practices for outreach and enrollment assistance. A number of promising practices to enhance enrollment activities were identified:

- OW's consistently identify word of mouth as the most effective way of reaching the uninsured and highlight the importance of maintaining a relationship of trust with clients, discussing the types and importance of mail from MassHealth, and reiterating the availability of the OW for assistance with forms as they arrive.

- The OWs identified the importance of ongoing education regarding insurance and of scheduling follow up according to the client's redetermination schedule.
- OWs often reside in the communities they serve and/or mirror their clients' cultural and linguistic characteristics. This significantly contributes to their ability to build trust, easing the way for engaging clients in getting the assistance to which they are entitled. Clients often travel further than necessary for a meeting with a specific OW based on the recommendation of family or friends.
- Importantly, the OWs describe specific client needs beyond enrollment and re-certification which they are able to help resolve. The OWs help clients select a health plan and find a culturally and linguistically sensitive primary care provider (PCP).

In addition to the MassHealth grant program, the Blue Cross/Blue Shield Foundation currently funds approximately 23 additional *Connecting Consumers with Care* grants ($20,000-$25,000 each) that together assist from an estimated 1,800-8,000 individuals per month. [i] The organizations include community services organizations serving a wide range of ethnic and racial minority communities. One example of these grantees is Health Care for All, a statewide consumer advocacy organization that maintains a consumer helpline to assist individuals in locating and enrolling in affordable health insurance, fielding almost 40,000 calls from consumers each year. HelpLine counselors assist beneficiaries with: initial enrollment document submission and follow-up tracking; linguistic interpretation; response to verification notices; reapplication and reenrollment processes; plan and provider selection; appeal and adjudication of eligibility determination decisions; and transitions between plans. However, since its initiation, there have only been two small behavioral health organizations included in the Blue Cross/Blue Shield program. As such, behavioral health organizations have very limited organized involvement in assisting clients in enrollment.

MassHealth staffs a central eligibility processing unit and four enrollment centers, which, prior to the 2006 healthcare reform efforts, were responsible for MassHealth Programs and the Health Safety Net. They are now also responsible for processing Commonwealth Care applicants in person, by mail, and over the phone. Performance requirements for the processing units focus on quantitative

measures of productivity such as the number and duration of applications and number of supporting documents in queue.

### Coverage Continuity Efforts

MassHealth has created two types of confidentiality-related release forms for applicants or enrollees to complete that allow MassHealth to share eligibility information with designated individuals or organizations: the "Eligibility Representative Designation" and the "Permission to Share Information" (PSI) form. An applicant or member can select an eligibility representative designee who knows enough about the applicant or member to help them through the eligibility process. The eligibility representative designee must know enough about the applicant or member to take responsibility for the correctness of the statements made during the eligibility process. This eligibility representative designee has the authority to make decisions and take actions related to the enrollee's eligibility and enrollment without the enrollee's participation. However, the enrollee can only appoint an individual, and not an organization, to hold the responsibility for serving as the eligibility representative designee, which can itself at times create discontinuities. Because the eligibility representative may be a staff person in a social service or provider organization, rather than the organization, when staff leave or shift roles, the enrollee may potentially lose the link to their eligibility representative designee.

The "Permission to Share Information" form is completed by the applicant or enrolled member to designate an individual or an organization that MassHealth can share their eligibility information with. This form allows the sharing of eligibility notices and information related to the applicant or member's eligibility status but this designee is not given authority to act for the enrollee in enrollment matters. This information is still very helpful, as the PSI designated individual or organization can provide valuable assistance to the applicant or enrolled member by alerting them to MassHealth requests for information, in explaining program enrollment requirements, and in facilitating access to the Virtual Gateway, thereby helping the individual obtain and retain health insurance coverage.

In April 2010, MassHealth implemented a simplified administrative renewal process for MassHealth members residing in nursing facilities if they have Social Security as their sole source of income and Medicare as well as Medicaid health insurance coverage. At their renewal date, MassHealth sends them the eligibility form along with a cover letter that advises the enrolled member that his or her

eligibility has been reviewed electronically and, unless there are changes to report, no further action is needed. Unless contacted, the default action is continued enrollment. This renewal process is completed through use of data matching with information received from the Federal government, especially the Social Security benefit information. Massachusetts plans to expand this project to certain elderly and disabled populations living in the community who meet similar criteria, such as those that are dually enrolled in Medicare and Medicaid. Individuals with chronic behavioral health conditions may be included in the process if they are elderly, disabled under Social Security Disability Insurance (which ultimately grants Medicare coverage) and meet other administrative review criteria.

Finally, outreach workers can utilize the My Account Page to see when individuals they are assisting are due for their annual eligibility review. Outreach workers then proactively contact enrolled members to let them know when their recertification of continued eligibility review is up coming and to inform them when there are an available resource to assist them completing and submitting the paperwork to MassHealth. Similarly, MassHealth provides a monthly schedule to Managed Care Organizations (MCO) of enrollees who will be reviewed for eligibility. This allows those organizations to follow up with their enrollees to remind them to complete the recertification forms.

## ENROLLMENT CHALLENGES, CHURN AND THEIR CONSEQUENCES

MassHealth and Commonwealth Care enrolled members have certain member responsibilities that are outlined on the MassHealth website, in the Member Booklet, and in MassHealth regulations. Some of the responsibilities include responding to information requests, reporting significant life changes and completing the annual review process. If any documentation of information is needed and MassHealth is unable to verify it through data matching, a request for information will be sent. If the individual does not provide the proof, MassHealth may deny benefits. Members are also required to report any changes in status (such as address changes, income changes etc.) within 10 days of the change to ensure MassHealth has up to date information. During the annual recertification review, the member is required to return the review and any requested documentation within the specified time frames or the member's coverage may be terminated.

Findings from this research confirm that enrollment processes are difficult for those with behavioral health problems and that other MassHealth initiative to connect with providers and plans largely leave out behavioral health providers and carve-out plans. Behavioral health patients in the focus groups described the process for applying, completing information requests, and reapplying to MassHealth and Commonwealth Care as complex, burdensome and confusing. These patients described the experience taking between 45 minutes to 2 hours to complete the eligibility determination and enrollment forms, not including time for gathering, copying, and mailing supplemental verification documents like pay stubs, birth certificates, and proof of identity. Many enrollees reported utilizing safety net providers, Help-Line call center staff, Virtual Gateway providers, and MassHealth enrollment center personnel to complete these processes. However, small primary care practices or behavioral health providers do not generally have access to the Virtual Gateway portal, thus dramatically limiting its functionality for many consumers of behavioral health services. Although the Medicaid Management Information System (MMIS) system does provide MCO's with a list of enrollees who will soon be reviewed for eligibility, most behavioral health clients are enrolled in the Massachusetts Behavioral Health Plan, a carve-out from the physical health HMO program, and the carve out does not receive a monthly schedule of re-certifications.

### Enrollment Challenges

Overall, with a total of 1.3 million total beneficiaries enrolled in Mass Health[xxii], 160,000 beneficiaries enrolled in Commonwealth Care, and an estimated 35,000 eligible but not enrolled in Commonwealth Care, there is an immense number of transactions involved in enrolling new members, annually recertify existing members, verify data for existing members, and re certifying members whose coverage was terminated. Each of these transactions represents a churn opportunity for individuals to unnecessarily lose eligibility, requiring reapplication at a later time.

The discussion with policymakers, advocates, and beneficiaries revealed the following areas likely to increase disenrollment events:

1. Application/recertification submissions with missing or incomplete documentation;
2. Frequent change of enrollee address or lack of permanent address leading to termination of coverage due to returned mail or failure to respond;

3. Barriers complying with MassHealth requests due to acute and chronic conditions, especially severe mental health and substance use disorders, and long term disabilities that require continuing, or even permanent, medical support; and

4. Lack of awareness or understanding of the consequences of not promptly reporting life changes, such as changes in address, income, numbers and ages of dependents, and other conditions that trigger termination from the enrolled program. This can create a failure to respond to the verification requests which may result in termination of coverage.

Despite mailing of standardized notices from MassHealth or Commonwealth Care, beneficiaries nearly unanimously reported they were uninformed about their actual or impending disenrollment. The reasons for being uninformed included: anxiety about formal government notifications, comprehension difficulties in understanding the request, and the failure to see or receive the notice due to housing instability, treatment admissions or other causes.

A number of the substance abuse treatment patients mentioned being disenrolled due to fluctuations in income. Income volatility among the socio-economic status (SES) categories eligible for Medicaid and Commonwealth Care has increased over recent years.[xxiii] All members are required to report changes to MassHealth within 10 day of the change in status, which includes changes in income. MassHealth does perform data matching with Federal and state agencies to make every effort to electronically verify information such as income. If there is a change that cannot be verified through data matching, a member may be sent a request for verification. If this information is not returned to MassHealth within the specified time period, a member's coverage is often terminated.

The consequences of churn are significant for all involved, but especially for beneficiaries. The lack of health insurance coverage has a significant adverse impact on health status. Utilization of needed services is often deferred when the patient is aware of the gap, and for the behavioral health patient, this can mean that continuing rehabilitation care or recovery support service are not available following detoxification, that medication compliance is not monitored, or that counseling is not available to complement medication therapies. For the numerous patients who lose their health insurance coverage, the consequences often transfer to the provider that must subsidize the care; to the navigator-support system that helps to reenroll the beneficiary; and to the insurer that bears the

administrative costs of disenrollment and reenrollment processes, as well as the downstream medical costs of deferred or delayed care. Navigators, advocates, and outreach and enrollment assistance workers with access to individuals with behavioral health conditions and the competencies to help them, are crucial for the success of the system. This not only supports access to needed care but also diminishes costly burdens to re-enroll individuals for providers, outreach workers, health insurance plans and the government.

## RECOMMENDATIONS FOR MAINTAINING COVERAGE CONTINUITY

This report has outlined the intricacies of the Massachusetts eligibility and enrollment system, summarized some of the strategies MA has developed to improve its functioning, and identified some of the issues contributing the enrollment and churn challenges facing the behavioral health population. Many of the systemic issues have been addressed in the proposed regulations released by CMS as a part of the implementation of the Affordable Care Act (ACA). However, we have identified a number of specific recommendations to address the issues identified in this report that all States can explore adopting as they move toward January 1, 2014.

The findings of the study lead to recommendations that include:

1. Develop behavioral health oriented enrollment navigator-support assistance including access to the Virtual Gateway platform at key locations that serve the most disabled and vulnerable populations, including, but not limited to: TANF offices, community mental health and specialty addiction treatment centers, legal aid, community health center, homeless services sites, and hospital emergency departments.
2. The more flexible administrative renewal processes should be extended to populations that: meet administrative renewal criteria such as government only income sources, are disabled, or are receiving care for chronic behavioral health conditions.
3. Utilize the MMIS system to provide monthly alerts on recertifications to all MCO's including behavioral health carve out plans and require the plans follow up with their enrollees to remind them to complete the recertification forms.

4. Within the limitations of existing law and regulations, develop an income change calculation and notification policy designed to maximize continuity in coverage and minimize unnecessary enrollee response requirements. Future changes in the Affordable Care Act should simplify income determination and increase data matching from Federal sources.
5. Develop customized enrollment and recertification assistance training and infrastructure supports for providers serving high rates of uninsured behavioral health patients.
6. Customize marketing, public education, and enrollment assistance campaigns targeting young healthy men, racial and ethnic minorities, and other populations with high numbers of chronically uninsured individuals.
7. States should conduct an annual 'leadership enrollment walk-through' for state Medicaid and behavioral health agency leadership to increase understanding on different aspects of enrollment and to formulate better system processes, coordination between programs and improved performance.
8. Use clear, concise, and simple content that is available in multiple languages for all communications, including outreach, application, recertification, and reenrollment documents. Public awareness efforts should be distributed via traditional mail, email, and through third-party representatives for the most disabled.
9. Establish standardized enrollment and disenrollment performance metrics, including, but not limited to: numbers of applications and reapplications in queue, length of processing time, rates of disenrolled who become reenrolled within specified time frames (e.g. 1-3 months), and average disenrollment period for eligible but not enrolled. Standardized performance metrics will help track and improve enrollment system issues.
10. Design and make widely available to all applicants, providers and the public detailed process maps that illustrate the flow of an application with required information at each step from initial request to recertification, including verification processes. The more individuals and provides understand the processes of the eligibility and enrollment system,

the more likely that they can successfully negotiate enrollment processes and requirements and thereby keep coverage when they are still eligible.

## CONCLUSION

The eligibility determination, enrollment, and recertification system in Massachusetts can serve as a helpful case study for other States as they prepare for expansions in eligibility and for the implementation of new regulations for streamlined eligibility determination and enrollment processes. As this research and report indicate, State choices at each step in the process can have a significant impact on the ability of eligible individuals' with behavioral health conditions access and maintain affordable health insurance coverage. The Affordable Care Act embodies an opportunity to provide coverage to more than 11 million[xxiv] currently uninsured individuals with behavioral health needs. Through the efforts already underway and the recommendations outlined in this report, the Federal government and States can take advantage of this opportunity to develop an accurate, efficient, and streamlined eligibility determination and enrollment process.

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